

Transplant Nursing

patients is at the highest risk of developing significant problems that would require hospitalization. Despite this high risk, the use of PBSC with higher-than-average CD34 counts, the predictability and consistency of engraftment, and the use of once-daily broad-spectrum antibiotics facilitates outpatient care delivery. A total of 279 malignant hematology patients (53% NHL, 32% MM, 15% HD) who underwent autologous HSCT over the last 5 years were reviewed for evaluation of the safety of this outpatient program. In this group, 63% were male and 37% female, and the average age was 47 years (range, 13–68 years). The average LOS was 11.3 days as an outpatient and 12.4 as an inpatient. Eight patients were admitted to ICU from the outpatient program within 24 hours, with 1 death. Common complications were related to febrile neutropenia or bacteremia. This presentation will outline the interventions used by nurses in the program to maintain safe and effective patient care in the outpatient setting.

297**INFECTION IN THE PEDIATRIC PATIENT AFTER BONE MARROW OR STEM CELL TRANSPLANTATION: NURSING CONSIDERATIONS**

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Infection remains the leading cause of death in pediatric patients undergoing bone marrow or stem cell transplantation despite new medications and treatment modalities. Diagnosis of these infections has become easier due to newer diagnostic technologies. Treatment options for these patients have also greatly improved, primarily related to earlier detection and implementation of appropriate drug therapies. Risk factors for life-threatening infections include, but are not limited to, increased numbers of unrelated transplantations with subsequent prolonged periods of aplasia. The prolonged period of aplasia often places the patient at a higher risk of acquiring multiple infections at the same time. Bacterial, viral, and fungal infections can occur at any time during the transplantation trajectory. However, due to the engraftment of different infection-fighting cells at different points in the timeline, certain infections are more likely to occur at certain (predicted) periods during the course of transplantation. Early detection and treatment offer the patient the best options for treatment and eradication of the infecting organism.

The purpose of this abstract is to describe the common infections associated with bone marrow and stem cell transplantation. The established guidelines for early detection and intervention will be discussed, as will the “gold standard” for treatment of these organisms. Nursing considerations related to the prevention, diagnosis, and treatment of these diseases will be discussed. A timeline for when the prevalent organisms are likely to occur will also be shared. Finally, a guide for the prevention of nosocomial infections will be presented. Nosocomial transmission of infections remain an all-too-common, but avoidable, occurrence. Heightened awareness of infection control practices can greatly reduce the risks of hospital-acquired infections.

298**MENTORING: “BRIDGING THE GAP” FOR TRANSPLANTATION COORDINATORS IN ONE OF THE LARGEST TRANSPLANTATION PROGRAMS IN THE COUNTRY**

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Mentoring a clinical nurse to the complex role of the blood and marrow transplantation (BMT) coordinator requires assessment of the nurse's skills and knowledge base to formulate an orientation plan that bridges the gap into the evolution of a BMT coordinator. Orientation includes the complexity of the patients' needs, research protocols, team building, communication/organizational skills, and the organizational/operational needs of the program and center.

Currently, the BMT Center employs 5 coordinators, with varying work backgrounds, who are each responsible for the coordination of pretransplantation care of patients for 2 or 3 physicians. Therefore, the orientation process must be tailored to the new employee's individual needs as well as the needs of the program

and center. In 2003 a BMT orientation manual was developed for the existing coordinator group; however, with an influx of new staff members, it was found to be confusing for staff who are inexperienced in BMT. Through the process of orienting new staff members, the orientation manual was expanded to encompass basic oncology as well as BMT-related information. Computer skills required for communication among the multidisciplinary care team, and sample orders to meet policy and procedures within the BMT Center, were also incorporated. New employees to the coordinator role are assessed for their oncology/BMT knowledge base, by reviewing prior experience and quizzing them on their knowledge. They are also supplemented with additional course work to improve knowledge base. Each novice staff member is paired with an experienced BMT coordinator for a period of 2–3 weeks after basic knowledge base and computer/communication skills are attained. On completion of orientation, the “coordinator orientation checklist” is completed and placed in the employee file.

Through the use of the expanded orientation manual and the mentoring from experienced coordinators, the novice coordinator is better prepared to work effectively in the coordinator role. Likewise, with continued mentoring, education, applicable in-services, and the manual as a resource, they are able to work independently to facilitate seamless care for the transplantation patient.

299**QUALITY IMPROVEMENT: A TRULY INTERDISCIPLINARY APPROACH**

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Patient satisfaction surveys are distributed monthly in the Blood and Marrow Transplantation Clinic at our center. The results of these surveys led the clinic management team to identify the following problems: clinic wait times, missed appointments, unanswered telephones, and unanswered voice mail messages. Process improvement teams had been identified to work through the problem list using the “plan, do, check, act” methodology. Progress was discussed at the weekly operations meeting attended by managers and updates were provided at faculty meetings. These items were also discussed at staff center wide meetings, and e-mails were sent announcing any changes being made. Although every effort was made to inform personnel, the challenge facing the management team was to ensure that the entire BMT clinic staff knew what was being done to improve these processes. An interdisciplinary BMT Clinic quality improvement team was established to facilitate an exchange of ideas and obtain faculty input. Members of the faculty and representatives of all clinic work groups met to discuss the issues and what had been done thus far. The problems were prioritized, and new working groups that included faculty members were formed to address these problems. The staff were asked to write incident reports for anything that did not go as planned; these were used to trend issues and identify new problems. This information was taken to the clinic QI group, and priorities were changed to address any pertinent findings. The result was a team effort of process improvement with faculty support and input. Patient satisfaction results, comment cards, and a decline in incident reports for those problems identified will be used to measure any improvement. It is hoped this effort will result in improved communication and sharing of information throughout the program.

300**CELEBRATION OF LIFE: THE FIRST BLOOD AND MARROW TRANSPLANTATION SURVIVOR'S DAY AT ONE OF THE LARGEST TRANSPLANTATION CENTERS IN THE COUNTRY**

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More than 550 blood and marrow transplantation patients and their families from a 5-state area attended the first M.D. Anderson BMT Survivor's Day Celebration on June 13, 2004. Planning for the celebration started 7 months earlier with a multidisciplinary team of approximately 25 staff members from both the adult and pediatric BMT programs. Multiple subcommittees were formed to